

**COMPLETE ENTIRE FORM AND SUBMIT PEDIGREE/CLINIC NOTES/
PATHOLOGY REPORT TO AVOID DELAYS**

To submit an order via email, please send the completed test requisition form to info@ambrygen.com

PATIENT INFORMATION					
Name (Last, First, MI)			Sex at Birth <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth (MM/DD/YY)	MRN
Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Portuguese <input type="checkbox"/> Other:					Ashkenazi Jewish <input type="checkbox"/> Yes <input type="checkbox"/> No
Address		City		State	Zip
Phone		Email		Preferred Billing <input type="checkbox"/> Insurance <input type="checkbox"/> Self-pay <input type="checkbox"/> Institutional	
SPECIMEN INFORMATION					
Both normal sample (e.g. blood or saliva) and tumor tissue required. Detailed specimen requirements can be found at ambrygen.com/specimen-requirements					
Blood/saliva	Collection Date:	Specimen ID #:	Specimen Collection Options: <input type="checkbox"/> Phlebotomy draw <input type="checkbox"/> Insurance preverification first <input type="checkbox"/> Send blood kit to patient* <input type="checkbox"/> Send saliva kit to patient		
Tumor	Please fill out the "Tumor Specimen Intended for Testing" section on page 2.		* As the patient's clinician, I am unaware of any potential for complication or difficulty in drawing blood for the listed patient(s). I understand that the phlebotomist has full authority to refuse to draw any patient if the safety of the phlebotomist and/or patient(s) are in question.		
PATHOLOGY INFORMATION (REQUIRED) <input type="checkbox"/> Please retrieve specimen					
Pathology report for relevant tumor tissue specimen is REQUIRED for processing. Please include a copy when order is submitted. Tumor specimen will be returned after testing is completed.					
Institution Name		Pathologist		Phone	Fax
Address		City		State	Zip
ORDERING LICENSED PROVIDER/SENDING FACILITY					
Facility Name (Facility Code)		Address	City	State /Country	Zip
Ordering Licensed Provider Name (Last, First)(Code)		NPI#	Phone	Fax/Email	
ADDITIONAL RESULTS RECIPIENTS					
Genetic Counselor or Other Medical Provider Name (Last, First) (Code)			Phone/Fax/Email		
Other Medical Provider Name (Last, First) (Code)			Phone/Fax/Email		
CONFIRMATION OF INFORMED CONSENT, PRE-TEST GENETIC COUNSELING, AND MEDICAL NECESSITY FOR GENETIC TESTING					
The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate consent. I confirm that testing is medically necessary and that test results may impact medical management for the patient. I agree to allow Ambry Genetics to facilitate the provision of pre-test genetic counseling services by a third-party service, as required by the patient's insurance provider. Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the attached letter of medical necessity.					
Signature Required for Processing Medical Professional Signature:				Date:	
<input type="checkbox"/> INSURANCE BILLING (Include copy of both sides of insurance card)			<input type="checkbox"/> INSTITUTIONAL BILLING		
Patient Relation to Policy Holder? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		Name and DOB of Policy Holder (if not self)		Facility Name <input type="checkbox"/> Send invoice to facility address above	
Insurance Company		Policy #	HMO Auth #	Address	
Out of Pocket (OOP): Upon receipt of all required specimens, we will start testing immediately. We will attempt to contact the patient if the estimated out-of-pocket costs are > USD \$100.			Contact Name		
Special Billing Notes:			Phone Number		E-mail/Fax
			<input type="checkbox"/> PATIENT PAYMENT		<input type="checkbox"/> Check (Payable to Ambry Genetics) <input type="checkbox"/> Credit Card (Call 949-900-5795)
Patient Acknowledgement: I acknowledge that the information provided by me is true and correct. For direct insurance billing: I authorize my insurance benefits to be paid directly to Ambry Genetics Corporation (Ambry), authorize Ambry to release medical information concerning my testing to my insurer, to be my designated representative for purposes of appealing any denial of benefits as needed and to request additional medical records for this purpose. I understand that I am financially responsible for any amounts not covered by my insurer and responsible for sending Ambry money received from my health insurance company. For patient payment by credit card: I hereby authorize Ambry Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for Ambry's Patient Assistance Program, please provide the total annual gross household income: \$ [] and the number of family members in the household supported by the listed income: []. I authorize Ambry Genetics Corporation to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation.					
For NY Residents: <input type="checkbox"/> I am a New York resident and I give Ambry Genetics permission to store my sample for longer than 60 days. NOTE: If left blank, consent is interpreted as "NO".					
Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent:				Date:	

Tumor Test Requisition Form - Page 2 of 3

PLEASE SUBMIT THE FOLLOWING WITH THE TRF:

1. Clinic Notes 2. Pedigree 3. Insurance Card 4. Pathology Report

PATIENT CLINICAL HISTORY (Please indicate if diagnosis is active)											
<input type="checkbox"/> No personal history of cancer			<input type="checkbox"/> History of allogenic bone marrow or peripheral stem cell transplant**			ICD-10 code(s):					
Cancer/Tumor	Active	Age at Dx	Pathology and Other Info								
Breast	<input type="checkbox"/>		Type: ER <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk PR <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk HER2/neu <input type="checkbox"/> (+) <input type="checkbox"/> (-) <input type="checkbox"/> unk Metastatic: <input type="checkbox"/> Y <input type="checkbox"/> N								
Colorectal	<input type="checkbox"/>		Location:								
Uterine	<input type="checkbox"/>										
Ovarian	<input type="checkbox"/>		<input type="checkbox"/> Fallopian tube <input type="checkbox"/> Primary peritoneal								
Prostate	<input type="checkbox"/>		Gleason Score:					Metastatic: <input type="checkbox"/> Y <input type="checkbox"/> N			
Other Cancer	<input type="checkbox"/>		Type:								
Other clinical history:											
**Blood or saliva from patients with active/recent hematological disease or a history of allogenic bone marrow or stem cell transplant should not be used for genetic testing. For these patients, an alternative specimen (e.g. cultured fibroblasts) is recommended. See ambrygen.com for details.											
PATIENT GENETIC TESTING HISTORY Lynch syndrome tests only: This section must be completed for Medicare beneficiaries											
<input type="checkbox"/> No previous molecular and/or genetic testing											
Genetic testing Test(s) performed: _____					Microsatellite instability analysis:						
Result(s): _____					<input type="checkbox"/> Stable (MSS) <input type="checkbox"/> Unstable/high (MSI-H) <input type="checkbox"/> Unstable/low (MSI-L)						
Please include copies of any previous genetic test results.					IHC, if multiple primaries, tumor used: _____						
					<input type="checkbox"/> Proteins present: _____ <input type="checkbox"/> Proteins absent: _____						
					<input type="checkbox"/> Tissue is unavailable or insufficient for IHC/MSI testing						
FAMILY HISTORY [^]											
[^] Completing this section is not mandatory for ordering if a pedigree and/or clinical note with family history is supplied, but is recommended and helps with results interpretation and claims filing.											
<input type="checkbox"/> None (maternal) <input type="checkbox"/> None (paternal) <input type="checkbox"/> Maternal history unknown <input type="checkbox"/> Paternal history unknown											
Relation to patient	Maternal	Paternal	Cancer/Polyp Type	Dx age	Relation to patient	Maternal	Paternal	Cancer/Polyp Type	Dx age		
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>				
TESTS REQUESTED											
Check to order	Test Name	Test Code	Tumor Specimen Intended for Testing								
<small>Both normal sample (e.g. blood or saliva) and tumor tissue are required. Please see specimen preparation instruction sheet for more detailed specimen requirements.</small>			Specimen & Block ID	Primary Tumor Type/Site	Metastatic Site, if applicable ^{††}						
<input type="checkbox"/>	Lynch syndrome paired testing ^{^^}	8982									
<input type="checkbox"/>	TumorNext [®] -Lynch ^{^^}	8980									
<input type="checkbox"/>	TumorNext-Lynch plus ColoNext ^{®^^}	8981									
<input type="checkbox"/>	TumorNext-Lynch plus BRCANext-Expanded ^{TM^^}	8985									
<input type="checkbox"/>	TumorNext-Lynch plus CancerNext ^{®^^}	8984									
<input type="checkbox"/>	Add on BRAF (V600E), KRAS, and NRAS targeted analysis (This can only be applied to test options above.)										
<input type="checkbox"/>	Microsatellite instability (MSI) analysis ^{^^†}	8702									
<input type="checkbox"/>	MLH1 promoter hypermethylation analysis ^{^^}	7978									
<input type="checkbox"/>	TumorNext-BRCA [†]	9810									
<input type="checkbox"/>	TumorNext-HRD [†]	9811									
<input type="checkbox"/>	TumorNext-HRD plus BRCANext-Expanded [†]	9814									
<input type="checkbox"/>	TumorNext-HRD plus CancerNext [†]	9813									
^{^^} Lynch syndrome tumors will be accepted. Visit ambrygen.com for more details.											
[†] Ovarian tumors (including Fallopian tube and primary peritoneal) will be accepted. For other cancer types, please discuss with your Ambry Account Manager.											
^{††} Please indicate the organ the tumor metastasized to from the original primary tumor site.											
Will the course of treatment change depending upon the results of the test? <input type="checkbox"/> Yes <input type="checkbox"/> No					For assistance regarding requested tumor samples, please call 949.900.5783.						
Notes:											

Supplemental Information - Page 3 of 3

Test Name	Test Code	Description
Lynch syndrome paired testing	8982	Paired tumor and germline testing of <i>MLH1</i> , <i>MSH2</i> , <i>MSH6</i> , <i>PMS2</i> , + <i>EPCAM</i> del/dup
TumorNext-Lynch	8980	Paired tumor and germline testing of <i>MLH1</i> , <i>MSH2</i> , <i>MSH6</i> , <i>PMS2</i> , and <i>EPCAM</i> ; microsatellite instability (MSI) and <i>MLH1</i> promoter hypermethylation analysis
TumorNext-Lynch plus ColoNext	8981	TumorNext-Lynch (described above) plus germline analysis of <i>APC</i> , <i>AXIN2</i> , <i>BMPR1A</i> , <i>CDH1</i> , <i>CHEK2</i> , <i>GREM1</i> , <i>MSH3</i> , <i>MUTYH</i> , <i>NTHL1</i> , <i>POLD1</i> , <i>POLE</i> , <i>PTEN</i> , <i>SMAD4</i> , <i>STK11</i> , and <i>TP53</i>
TumorNext-Lynch plus BRCANext-Expanded	8985	TumorNext-Lynch (described above) plus germline analysis of <i>ATM</i> , <i>BARD1</i> , <i>BRCA1</i> , <i>BRCA2</i> , <i>BRIP1</i> , <i>CDH1</i> , <i>CHEK2</i> , <i>DICER1</i> , <i>NBN</i> , <i>NF1</i> , <i>PALB2</i> , <i>PTEN</i> , <i>RAD51C</i> , <i>RAD51D</i> , <i>RECQL</i> , <i>SMARCA4</i> , <i>STK11</i> , and <i>TP53</i>
TumorNext-Lynch plus CancerNext	8984	TumorNext-Lynch (described above) plus germline analysis of <i>AXIN2</i> , <i>APC</i> , <i>ATM</i> , <i>BARD1</i> , <i>BMPR1A</i> , <i>BRCA1</i> , <i>BRCA2</i> , <i>BRIP1</i> , <i>CDH1</i> , <i>CDK4</i> , <i>CDKN2A</i> , <i>CHEK2</i> , <i>DICER1</i> , <i>GREM1</i> , <i>HOXB13</i> , <i>MSH3</i> , <i>MUTYH</i> , <i>NBN</i> , <i>NF1</i> , <i>NTHL1</i> , <i>PALB2</i> , <i>POLD1</i> , <i>POLE</i> , <i>PTEN</i> , <i>RAD51C</i> , <i>RAD51D</i> , <i>RECQL</i> , <i>SMAD4</i> , <i>SMARCA4</i> , <i>STK11</i> , and <i>TP53</i>
TumorNext-BRCA	9810	Paired tumor and germline analysis of <i>BRCA1</i> and <i>BRCA2</i>
TumorNext-HRD	9811	Paired tumor and germline analysis of <i>BRCA1</i> , <i>BRCA2</i> , <i>ATM</i> , <i>BARD1</i> , <i>BRIP1</i> , <i>CHEK2</i> , <i>MRE11A</i> , <i>NBN</i> , <i>PALB2</i> , <i>RAD51C</i> , and <i>RAD51D</i>
TumorNext-HRD plus BRCANext-Expanded	9814	TumorNext-HRD (described above) plus germline analysis of <i>CDH1</i> , <i>DICER1</i> , <i>EPCAM</i> , <i>MLH1</i> , <i>MSH2</i> , <i>MSH6</i> , <i>NF1</i> , <i>PMS2</i> , <i>PTEN</i> , <i>RECQL</i> , <i>SMARCA4</i> , <i>STK11</i> , and <i>TP53</i>
TumorNext-HRD plus CancerNext	9813	TumorNext-HRD (described above) plus germline analysis of <i>APC</i> , <i>AXIN2</i> , <i>BMPR1A</i> , <i>CDH1</i> , <i>CDK4</i> , <i>CDKN2A</i> , <i>DICER1</i> , <i>EPCAM</i> , <i>GREM1</i> , <i>HOXB13</i> , <i>MLH1</i> , <i>MSH2</i> , <i>MSH3</i> , <i>MSH6</i> , <i>MUTYH</i> , <i>NF1</i> , <i>NTHL1</i> , <i>PMS2</i> , <i>POLD1</i> , <i>POLE</i> , <i>PTEN</i> , <i>RECQL</i> , <i>SMAD4</i> , <i>SMARCA4</i> , <i>STK11</i> , and <i>TP53</i>